Empowering Choices

Counseling & Consultation

805 Liberty St NE Suite 2
Salem, OR 97301

Release of Information

Authorization of Disclosure of Records

I hereby authorize _____, Counselor, to disclose/ receive the following information to/from the records of:

Client name:_____ DOB:_____

To/From (Name of other party):

_____

Phone:_____ Fax:_____

Address:_____

I specifically authorize the release of the following:

Please check information to be disclosed:

___ Assessment and Diagnosis
___ Psychiatric/Mental Health Treatment Records
___ Progress in Treatment
___ Drug and Alcohol Treatment Records
___ Evaluations
___ Treatment Plans
___ School Records
___ Entire Health Record
___ Other: Specify _____

The above information will be used for the following purposes: diagnosis and treatment, coordination of mental and medical health care, administration of health care service plans, coordination of family treatment and/or other (specify):

_____

I hereby authorize the use or disclosure of my protected heath information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand this authorization is voluntary and I may refuse to sign

it. I understand I may revoke this authorization at any time by giving written notification to my provider. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. I understand that, if the recipient is not a health care provider or health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it. This consent is effective for one (1) year from the date it is signed unless otherwise specified as follows:

_____

Signature of Client: _____ Date: _____